PROTECTING CHILDREN: Substance Abuse and Child Welfare Working Together

Executive Summary of Regional Meetings
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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EXECUTIVE SUMMARY OF REGIONAL MEETINGS

INTRODUCTION AND PURPOSE

The Division of State and Community Assistance of the Center for Substance Abuse Treatment (CSAT), in conjunction with the Administration on Children, Youth and Families (ACYF), held four, two-day state team-building workshops between May and September, 2001. The workshops were titled, *Protecting Children: Substance Abuse and Child Welfare Working Together*. They were held in Savannah, GA (May 8-9); Chandler, AZ (May 22-23); San Francisco, CA (August 7-8); and Boston, MA (September 11-12). These workshops were designed to help build the state infrastructure necessary to bring about coordinated delivery of care for children in the child welfare system and their parents in substance abuse treatment.

The federal sponsors invited states to send teams of six individuals representing single state alcohol and other drug agencies, state child welfare agencies, members of the judiciary, and other agencies and individuals involved with families, including foster care, TANF, Medicaid, advocacy groups, and consumers. Speakers included representatives of these groups, as well as individual providers of substance abuse treatment and child welfare services.

Team members completed a Collaborative Values Inventory prior to attending the workshop. They heard presentations on such topics as the Adoption and Safe Families Act (ASFA), judicial decisions, family drug courts, and successful approaches to collaborative work. Participants also attended concurrent working sessions on topics that included confidentiality, interdisciplinary training, working with the judicial system, methamphetamine use and production and its effects on children and youth, safety and resilience of children in substance abusing families, and recognizing and understanding issues for women with co-occurring disorders and their children. The agenda for these workshops evolved from a national planning meeting held in Bethesda, MD, in November 2000.

BACKGROUND

Congress passed the Adoption and Safe Families Act (P.L. 105-89) in 1999. AFSA required the Secretary of Health and Human Services to prepare a report to Congress on substance abuse and child protection. Published April 1, 1999, the report is titled *Blending Perspectives and Building Common Ground.* This report includes information on the extent and scope of the problem, effective service delivery approaches, and recommendations for next steps.

The number one recommendation was to build collaborative working relationships between the child welfare and substance abuse treatment systems. In response, CSAT and ACYF executed a three-year interagency agreement to share resources to produce publications and co-sponsor meetings such as the four regional workshops.

The need for such collaboration is great. Some 80 to 85 percent of children in out-of-home placement are there because of parental addiction. But nationally, only 35 percent of the individuals in need of publicly funded substance abuse treatment receive it. ASFA provides both an opportunity and a responsibility for the child welfare and substance abuse treatment systems to work together.

THE ADOPTION AND SAFE FAMILIES ACT

The Adoption and Safe Families Act represents the first major piece of child welfare reform legislation in the past 20 years. In essence, ASFA codified the national consensus about the purpose of public child welfare services, which can be summed up by the words *safety*, *permanency*, and *well-being*. In particular, the legislation embodies the following key principles:

- Child safety is the primary concern that must guide all child welfare services.
- Foster care is a temporary setting and not the place for children to grow up.
- Permanency planning for children should be initiated as soon as the child is placed in a foster care setting.
- The child welfare system must focus on results and accountability.
- States should be given credit for innovative ideas on how to improve the child welfare system.

ASFA has the potential to be positive for children and parents if families get the services they need. Yet the timelines do cause tension. Fifteen months is a short time to recover from addiction and related social and health issues, but it's a long time in the developmental life of a child. (ASFA requires a state to petition for termination of parental rights if a child has been in foster care for 15 of the previous 22 months.) Providers need to redouble their efforts to make things work better.

VALUES CLARIFICATION: BUILDING TOWARD A JOINT MISSION

The number one need expressed by states prior to attending the regional workshops was the opportunity for both systems to come together to examine their values and beliefs and how these attitudes affect the way they work together. To this end, participants completed a pre-workshop questionnaire called the Collaborative Values Inventory.

The survey was designed to help the child welfare and substance abuse treatment systems 1) clarify the underlying values in collaborative work; 2) develop common principles and goals; and 3) uncover differences in values that may impede cross-system collaboration. Often,

differences in basic values and beliefs are the cause of the problem when even seemingly successful collaborations hit a roadblock.

Individuals who completed the survey represented alcohol and other drug services, children's services, dependency/family court personnel, Medicaid providers, and others. There was strong agreement among these respondents in some areas. For example, in all four regions, a majority of respondents agreed that solving the problems caused by alcohol and other drug use would improve the lives of a significant number of children, families, and others in need. They also agreed that alcohol and other drug providers should prioritize women from the child welfare system as their most important clients to receive services.

However, some interesting differences emerged, which can help pinpoint important areas states need to discuss. For example, respondents from the different systems were more divided in their opinions on such matters as whether illegal drugs or alcohol are a bigger problem in their communities, whether or not a parent who abuses alcohol or other drugs can be an effective parent, and whether or not urine screens are useful for determining a parent's readiness to retain or regain custody of his/her children (court respondents find them useful). They also were divided on the questions of whether services could be delivered more effectively by for-profit agencies, and whether the problems of family and children can best be addressed by government or non-governmental agencies.

Interestingly, respondents from alcohol and other drug services were most likely to *disagree* that people in recovery from substance abuse are the most effective counselors to work with their peers. This response is counter to conventional thinking and was consistent across all four regions. The answers might have been different if the survey was completed by line staff rather than by state agency representatives.

JUDICIAL DECISIONS: THE EYES OF THE CHILD

The Honorable William R. Byars, Jr. of the Children's Law Office at the University of South Carolina told participants at three of the four regional meetings that decisions concerning a child's future have to be made "through the eyes of the child." This, he said, was the essential paradigm shift that had to occur for the child welfare system to work effectively.

When a judge continues a case for 90 days, that may be considered a short period of time for the law, but it may seem like forever to a child who is not living at home. Children whose lives are in limbo feel afraid and helpless. Too often, Judge Byars said, the system treats the parents, but ignores the children, who are the true victims in these cases.

In the past family courts were concerned with two components–legal services and social welfare services. But the system has to have three components, much like a three-legged stool. The legs of the stool are legal services, social welfare services, and now substance abuse services. All three legs of the stool must be present. Judge Byars urged substance abuse professionals to be in court to help develop appropriate treatment plans.

FAMILY DRUG COURTS: RESPONDING TO CHILD AND FAMILY NEEDS

The first drug courts, begun in Miami in the late 1980s and early 1990s, recognized that jails and prisons were filled with nonviolent drug users, and that incarceration doesn't change an individual's behavior. Drug courts are a treatment-based process that merges rehabilitation with the judicial system. They have grown dramatically–there are now more than 450 such courts, including juvenile and family drug courts.

The drug court's primary concern is child welfare. Most children love their parents despite parental neglect, and most parents who are addicted to alcohol and drugs love their children. They don't want to continue their addictive behavior. Whenever possible, it's preferable to have children with their natural parents than with foster parents or relatives.

Key features of a drug court's success include support and accountability. The court has an investments in its clients. Accountability has both therapeutic and legal significance and differs from punishment. Drug courts can't make people change; they must be self-motivated and want to do it themselves.

SUCCESSFUL APPROACHES/BEST PRACTICES

Illinois: Empowering Families through Collaboration

Project SAFE is a collaborative effort between the Illinois Department of Children and Family Services and the Office of Alcoholism and Substance Abuse. Initially funded as a federal demonstration program, the program is now funded by the State of Illinois. The proof of Project SAFE's success is in the numbers: an 81 percent completion rate and a 54 percent reunification rate.

Project SAFE clients are neglectful mothers addicted to alcohol, and nearly 100 percent have histories of domestic violence, including sexual abuse. These women are difficult to engage, and they are at high risk for relapse, but relapse is viewed as an opportunity, not a measure of failure.

Outreach and transportation are two keys to Project SAFE's success. Outreach workers befriend the mother and gain her trust. They meet immediate needs and help remove barriers to substance abuse treatment. Transportation, initially viewed as an ancillary service, has become an important assessment tool. Mothers and children are more open to sharing as they ride a van to appointments. Van transportation has become a sort of "traveling therapy group."

Project SAFE program components also include referrals, intensive outpatient treatment, child care, parenting, case management/coordination, and joint administration and evaluation. Success with a program like Project SAFE requires commitment, shared responsibility, and ownership. Staff support is essential to prevent burnout. It's difficult to face this level of trauma and tragedy on a daily basis.

Connecticut: Retention of Women in Treatment

Connecticut was able to implement Project SAFE in phases, putting all the necessary elements in place in Phase I and improving services in Phase II. The Connecticut program also has a focus on experiential parenting.

Begun in 1995, Project SAFE in Connecticut is a collaboration among the State Department of Children and Families (DCF), the State Department of Mental Health and Addiction Services (DMHAS), and Advanced Behavioral Health, a network of nonprofit behavioral health providers. As part of Phase I, Project SAFE staff created a specialized screening tool that includes information about both substance abuse and child welfare issues, and developed specific consent forms. Phase II includes a focus on improved outcomes for women, children, and families.

The majority of women served by Project SAFE are ages 18 to 35. They are in low paying jobs, with many on welfare, and they have co-occurring trauma, depression, and other anxiety disorders. Cocaine is the most significant problem substance for women.

Most treatment programs stress a woman's role as a parent to provide for the physical needs of her children, and her very involvement in the child welfare system implies she has been a failure in this role. Few treatment programs address issues of emotional attachment and nurturing that allow a woman to discuss her feelings about her child and give her a positive incentive to stay in treatment. Project SAFE Phase II services include outreach and engagement, on-site child care, on-site parenting support, trauma education and treatment, and comprehensive substance abuse evaluations.

Much of the hard work of coordination and collaboration takes place at the local level. Statewide, the DCF/DMHAS partnership is based on: 1) designated leadership and project responsibility; 2) joint program planning and evaluation; 3) regional service team meetings; 4) cross-training forums; 5) co-contracting; and 6) resource development and shared funding.

Sacramento County's Experience: Trials, Tribulations, and Triumphs

Sacramento County has made several significant changes in alcohol and other drug treatment and child welfare services since the mid 1990s, and each time learned that incremental changes work best. Most people and systems don't want wholesale changes.

The goal of the **Alcohol and Other Drug Treatment Initiative** was to incorporate alcohol and other drug treatment services as an integral part of the health and human services delivery system and to build and expand service capacity. As a result of this initiative, child welfare clients received priority for AOD treatment, and the county expanded interim and group services to help achieve treatment on demand. Child welfare workers completed training in AOD treatment.

Strategies for Family Change is a multidisciplinary, neighborhood-based, strengths-based approach that treats the whole family as the client. This effort blends the "best of the best"

practice elements from the child welfare and alcohol and other drug treatment systems and stresses providing a menu of accessible services *tailored* to the unique needs of the family.

The **System of Care Model** relies heavily on making a thorough assessment of the client's and family's needs, including a complete biopsychosocial assessment and an indication of the individual's readiness for treatment. All providers use the Addiction Severity Index (ASI) and the American Society of Addiction Medicine (ASAM) placement criteria.

Lessons Learned. Communication and cooperation are better than nothing but do not represent true systems integration. So-called "complementary practice" is a compromise that includes a focus on the family, uses case management and case and family conferencing, and works to resolve confidentiality issues among systems. It's important to involve all key stakeholders and to have internal buy-in from within organizations. Finally, in addition to training, which is 25 percent of the solution, you need good tools, data, quality assurance mechanisms, and resources.

STATE TEAM REPORTS

One of the most important goals for these CSAT/ACYF workshops was to bring together state child welfare and substance abuse treatment systems to begin or continue collaborative efforts. State team representatives were asked to consider three key questions as they met together during the two-day workshop:

- Where were you at the start of the workshop as a state team?
- Where are you at the end of the workshop as a state team?
- Where are you going?

Some state representatives reported that they had been working together for years, but for many, these workshops were the first time they met their colleagues in other systems. They were grateful for the opportunity to learn about each other's perspectives and begin planning collaborative efforts. Many expressed a need to bring the judicial system into the loop and to educate judges about substance abuse. Team members also discussed the need to identify additional stakeholders, including representatives from mental health, vocational rehabilitation, and TANF. A number of the teams decided to keep meeting when they returned home and to become a force for change in their states and communities.